DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Corrected copy

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 1 0

2. STATE: MO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1,2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440 42 CFR 447.302 42 CFR 460
42 CFR 447.201 42 CFR 447.301

7. FEDERAL BUDGET IMPACT:
a. FFY _____ $ _____
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHED

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHED

10. SUBJECT OF AMENDMENT:
Coverage of Program of all - Inclusive Care for the Elderly (PACE)

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dana Katherine Martin

14. TITLE:
Director

15. DATE SUBMITTED:
May 22, 2001

16. RETURN TO:
Divsion of Medical Services
615 Howerton Court
P.O.Box 6500
Jefferson City, MO 65102-6500

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
05/24/01

18. DATE APPROVED:
AUG 22 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

SPA Control
Date Submitted: 05/23/01
Date Received: 05/24/01

FORM HCFA-179 (07-92)

Instructions on Back

c 10/2/01

Transmittal and Notice of Approval of State Plan Material

ATTACHMENTS:

8. Page Number of the Plan Section or Attachment:

a. Page 19c
b. Page 20b,
c. Page 9a of Attachment 3.1 A,
d. Page 9 of Attachment 3.1 B,
e. Pages 1a, 2a, 3a, 4a, 5a, 6a, 7a, 8a, 8b, 9a, 9b,10a, 10b,11a,12a, and 13a of Supplement 3 to Attachment 3.1 A,
f. Attachment A to Supplement 3 of Attachment 3.1 A, Section III, (A) (4), pages 7a-7c,
g. Attachment B to Supplement 3 to Attachment 3.1 A, Section III, (B), page 8a, and
h. Attachments 4.19 B, page 47.

9. Page Number of the Superseded Plan Section or Attachment:

a. Page 18h, Attachment 3.1 A (Rev. 12/99),
b. Page 18I, Attachment 3.1 A (Rev. 12/99), and
c. Page 9a-3a, Supplement 3 to Attachment 3.1 A.

State Missouri
PACE State Plan Amendment Pre-Print

Citation 1905(a)(26) ad 1934	3.1(a)(1)		Amount, Duration, and Scope of Services: Categorically Needy (Continued)
	(x)	X	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A Identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

State Missouri
PACE State Plan Amendment Pre-Print

Citation 1905(a)(26) and 1934	3.1(a)(2)	Amount, Duration, and Scope of Services: Medically Needy (Continued)
	(x) __	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B Identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

State Missouri
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically Needy

25. Home and Community Care for Functionally disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

__ Provided

X Not Provided

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

__ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State Missouri
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

25. Home and Community Care for Functionally disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

__ Provided

X Not Provided

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

X No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

X

[redacted]

July 31, 2001

Replaces SUPPLEMENT 3 TO ATTACHMENT 3.1-A, Page 3a, SP TN# 00-04

SUPPLEMENT 3 to ATTACHMENT 3.1-A
Page 1a

Name and address of State Administering Agency, if different from the State Medicaid Agency:
Same

State limit of PACE enrollees to be funded: 300.

State Missouri
PACE State Plan Amendment Pre-Print

I. Eligibility

A. X The State determines eligibility for PACE enrollees under rules applying to community groups.

B. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(v) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

The special income level group described at 1902 (a) (10) (A) (ii) (v).

C. __ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State monitoring of the PACE Program).

D. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

TN No.: 01-10
Supersedes TN No.: New Material

Approval Date AUG 22 2001
Effective Date 07-01-01

Regular Post Eligibility

1. ___ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
   1.____ The following standard included under the State plan (check one):
      (a) ___ SSI
      (b) ___ Medically Needy
      (c) ___ The special income level for the institutionalized
      (d) ___ Percent of the Federal Poverty Level:____%
      (e) ___ Other (specify):_____
   2. ____ The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.
   3. ____ The following formula is used to determine the needs allowance:
      _____
      _____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
   1. ____ SSI Standard
   2. ____ Optional State Supplement Standard
   3. ____ Medically Needy Income Standard
   4. ____ The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.
   5. ____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

6. ____ The amount is determined using the following formula:
_____
_____

7. ____ Not applicable (N/A)

(C.) Family (check one):
1. ____ AFDC need standard
2. ____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4. ____ The following percentage of the following standard that is not greater than the standards above:_____%
of_____ standard.
5. ____ The amount is determined using the following formula:
_____
_____
6. ____ Other
7. ____ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

1. X 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735**–States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)

   1. __ The following standard included under the State plan (check one):
      (a) ___ SSI
      (b) ___ Medically Needy
      (c) X The special income level for the institutionalized
      (d) ___ Percent of the Federal Poverty Level: _____%
      (e) ___ Other (specify):_____
   2. __ The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.
   3. __ The following formula is used to determine the needs allowance:
      _____
      _____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

   (B.) Spouse only (check one):

   1. __ The following standard under 42 CFR 435.121:
      _____
   2. __ The Medically needy income standard
      _____
   3. __ The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.
   4. __ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
   5. __ The amount is determined using the following formula:
      _____
      _____
   6. __ Not applicable (N/A)

(C.) Family (check one):

1. ____ AFDC need standard
2. ____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ___ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
4. ___ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5. ___ The amount is determined using the following formula:
   _____
   _____
6. ___ Other
7. ___ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

   (a.) Allowances for the needs of the:
      1. Individual (check one)
         (A.) X The following standard included under the State plan (check one):
            1. ____ SSI
            2. ____ Medically Needy

3. X The special income level for the institutionalized
4. ___ Percent of the Federal Poverty Level: ____%
5. ___ Other (specify):_____

(B). ____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C). ____ The following formula is used to determine the needs allowance:

_____
_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____
_____
_____

II. Compliance and State Monitoring of the PACE Program

For State Medicaid Agencies also serving as PACE State Administering Agencies, the State further assures all requirements of section 1934 of the Social Security Act will be met. All relevant provisions are included in the contract with the PACE entities, either as contractor or State responsibility. Both scheduled and unscheduled on-site reviews will be conducted by State staff.

A. Readiness Review: The State will perform a Readiness Review of the applicant entity that assures the entity has fully developed its policies and procedures, obtained commitments from key staff, developed its solvency plan and has a facility that meets State and Federal requirements at the time of the application, in accordance with Section 460.12(b)(1).

Monitoring During Trial Period: During the trial period, the State, in cooperation with HCFA, will conduct comprehensive reviews of a PACE organization to ensure compliance with State and federal requirements.

At the conclusion of the trial period, the State, in cooperation with HCFA, will continue to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with State and federal requirements.

C. Annual Monitoring: The State assures that at least annually it will reevaluate whether a participant meets the level of care required under the State Medicaid plan for coverage of nursing facility services. The State understands that this determination may be waived if there is no reasonable expectation of improvement or significant change in the participant's conditions because of the severity of a chronic condition or the degree of impairment of functional capacity.

D. Monitoring of Corrective Action Plans: The State assures it will monitor the effectiveness of corrective actions required to be taken by the PACE organization.

III. Rates and Payments

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

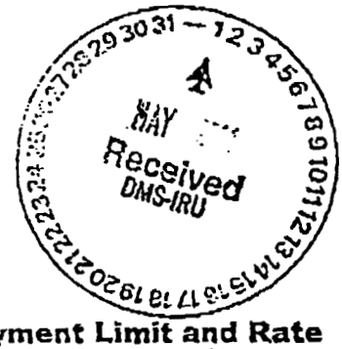
1. __ Rates are set at a percent of fee-for-service costs
2. __ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. __ Adjusted Community Rate (please describe)
4. X Other (please describe)

Attachment A to Supplement 3 of
Attachment 3.1-A, Page 1
Reference III. Rates and Payments
A.4, Page 7a [redacted]

WILLIAM M. MERCER

Proprietary and Confidential

April 26, 2001



Ms. Donna Siebeneck
Auditor III
Department of Social Services
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109

Subject: St. Louis Area PACE Upper Payment Limit and Rate Development

Dear Donna:

The State of Missouri (State) engaged William M. Mercer, Incorporated (Mercer) to review the State's development of the Upper Payment Limits (UPLs) and managed care capitation rates for the St. Louis area PACE program. The State used fee-for-service (FFS) data sources to determine the UPLs and then adjusted the UPLs to calculate the capitation rates. This letter will document the methodology the State used in developing the UPLs for the St. Louis area PACE program.

UPL Methodology

The State followed the methodology required by the Health Care Financing Administration in using only FFS data to calculate the PACE UPLs. The State used historical FFS data from the three most recent years of complete claims (i.e. – no completion factor adjustments were necessary) for eligibles meeting the following criteria:

- Age 55 and older;
- With Medicare (dual eligibles) or without Medicare coverage;
- In a nursing home for more than 32 days; and
- Residing in St. Louis and St. Louis City counties.

The FFS data reflects all FFS State Plan approved services which will be included in the capitation payment. In addition, this data was adjusted to reflect the following:

- Removal of GME;
- Removal of TPL;
- Removal of enrollee's cost share amounts;
- Reduction for the State's level of pharmacy rebates; and
- Application of any programmatic changes (i.e. – fee schedule and/or benefit changes).

William M. Mercer, Incorporated
800 LaSalle Avenue, Suite 2100
Minneapolis, MN 55402

Phone 612 642 8600
Fax 612 341 0232

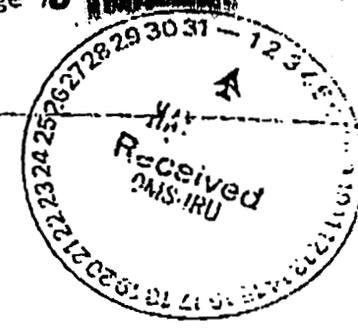
TN No: New Material
Supersedes TN No.: _____

Approval Date AUG 22 2001
Effective Date _____

An MMC Company

Attachment A to Supplement 3 of
Attachment 3.1-A,Page 2
Reference III. Rates and Payments
A.4, Page 76 [redacted]

WILLIAM M. MERCER



Once these adjustments were applied to the data, each year of data was then credibility adjusted and blended together to develop a base fee-for-service equivalent (FFSE). Credibility was applied using a mathematical formula applied over historical periods to determine outliers and to correct skewed distributions in claims history. Smoothing is done in a cost neutral manner.

The blended FFSE was then trended to the contract period. The trend was applied by category of service and was developed from historical FFS data from the three most recent years of complete claims and other expenditure data from Medicaid/Medicare resources.

Finally, this modified base FFSE was adjusted to reflect a UPL. In other words, a 3.5% load was applied to the per member per month to account for the State's administrative costs.

Once the State sets the UPLs using the above methodology, the State will update the UPLs by inflating them according to the following criteria:

- Inflation factors linked to State historical cost;
- Reimbursement for the FFS program above and beyond inflation; and
- Added benefits to the FFS program.

The State expects to rebase the claims data using the above methodology at least every five years.

Rate Methodology

The basis for the capitation rates is the contract period UPLs. The capitation rates are calculated by applying a budget percentage factor to the UPLs. This rate adjustment factor is an anticipated managed care savings reduction to the UPL. This guarantees that the State will not pay more than the UPL under this managed care program as required by regulation.

This reduction factor should allow the PACE providers to provide the covered services, cover their administrative expenses, and deliver quality care in the appropriate setting. This budget percentage factor accounts for the following differences between the managed care and FFS environments:

- The managed care program goal is to keep nursing home certifiable recipients in the community rather than in an institutionalized setting.
- Healthier individuals tend to select a managed care program. For example, PACE programs generally have significantly fewer enrollees that may have traumatic brain injuries or may be ventilator dependent.
- The enrollment criteria for the managed care program requires an assessment level based on the Activities of Daily Living assessment of 24 rather than the 18 required under FFS.

Attachment A to Supplement 3 of
Attachment 3.1-A, Page 3
Reference III. Rates and Payments
A.4, Page 7C
(7C)

WILLIAM M. MERCER

MAY 2001
Received
DMS-IRU

Therefore, the enrollees in the managed care program are expected to be healier than those in the FFS environment.

The capitation rates (and UPLs) were developed for two separate categories:

- Medicaid Only
- Dual Eligibles

These rates are fixed and will not change due to a participant's health status. These two rate categories have significant differences in the cost to the State (and the provider) based on the coordination with the Medicare program. Due to the small size of the program, developing additional rate categories by age or sex would be excessive and subject to greater volatility.

Rates will continue to be set in the above manner, and, again, the State expects to rebase the claims data using the above methodology at least every five years.

If you have any questions or concerns, please feel free to contact me at 612 642 8892.

Sincerely,

Angela L. WasDyke

Copy: Pam Victor
Michelle Raleigh
Mark Hoyt

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TN No: New Material
Supersedes TN No.: _____

AUG 2 2 2001
Approval Date _____
Effective Date 07-01-01

X

[redacted]

July 31, 2001
SUPPLEMENT 3 to ATTACHMENT 3.1-A
Page 8a

B. X The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

William H. Mercer, contact Angela WasDyke, (612) 642 8892.

Attestation/description is Attachment B to Supplement 3 to Attachment 3.1-A, page 1.

C. X The State will submit all capitated rates to the HCFA Regional Office for prior approval.

IV. Enrollment and Disenrollment: For both State Medicaid Agencies and State Administering Agencies, the State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month. In cases where the State Medicaid Agency is separate from the State Administering Agency, the State Medicaid Agency assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the two agencies.

A. Enrollment Process (Please describe):

The participant must reside in the specific geographic locale (St. Louis City and County); be age 55 or older; be assessed at the level of care (LOC) of 24 points or higher by Missouri Division of Aging (DA). Although Missouri's criteria for nursing home level of care (LOC) is a score of 18 points on this assessment, potential PACE participants, including any individuals who are not eligible for Medicaid, must have a score of 24 points or higher to ensure that he or she needs the level of care required under the State Medicaid plan for coverage of nursing facility services AND has a health status which is comparable to the health status of individuals's who participated in the PACE demonstration waiver programs.

Participants who are state only ME codes (Blind Pension (BP), CWS Foster Care (CWS-FC, General Relief (GR), DYS-General Relief, Catastrophic-QMB, Adoption Subsidy-HDN, Presumptive Eligibility (Non-Subsidized), CWS-HIF, or IM-GH-HIF) may enroll in the PACE program even if they do not qualify for Medicaid payment of the premium. Enrollment in this voluntary program is as follows after the above criteria has been met

WILLIAM M.
MERCER

May 1, 2001

PROPRIETARY & CONFIDENTAL

Mr. Greg Vadner
Director
Department of Social Services
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65101

Subject: St. Louis Area PACE Actuarial Attestation

Dear Greg:

William M. Mercer, Incorporated has reviewed the Upper Payment Limit (UPL) calculations and capitation rates developed by the State of Missouri (State) for the St. Louis Area PACE program. The UPLs and capitation rates are effective for the period of July 1, 2001 through June 30, 2002.

The UPL calculations are based on claim and enrollment data, which were summarized by the State. Mercer reviewed this data for reasonability and consistency. However, our review of the data did not include an audit. I have relied on the summaries prepared by Donna Siebeneck, Auditor III with the State.

The UPLs were calculated consistent with the Health Care Financing Administration requirements. The rates were determined by applying a budget percentage factor to the UPLs (Open Cooperative Contracting). I believe the actuarial assumptions made in the calculations to be reasonable.

I, the undersigned actuary, am available to answer any questions on this material or to provide explanations or further details as may be appropriate. You may contact me at 612 642 8892.

Sincerely,

Angela L. WasDyke

Angela L. WasDyke, ASA, MAAA

ALW/KB/sg

j:\ghcp\mlz01\pace\rates\pace attest doc

William M. Mercer, Incorporated
800 LaSalle Avenue, Suite 2100
Minneapolis, MN 55402

Phone 612 642 8600
Fax 612 341 0232

AUG 2 2 2001

X

[redacted]

July 31, 2001
SUPPLEMENT 3 to ATTACHMENT 3.1-A
Page 8b

PACE organization does an evaluation and plan of care of participant:

- If the potential participant selects PACE, the PACE organization will have the client sign an enrollment form and will forward a copy of the signed enrollment form to the Division of Aging on the same day or no later than next business day.

- Missouri Division of Aging notifies any current in-home providers to discontinue services and coordinates a closing date with the in-home services provider. No other in-home services shall be authorized by the Division of Aging. The in-home services must be closed on day, with PACE starting the next day.

- Missouri Division of Aging keys into the LTACs system the PACE enrollment with the effective date being the first day of the month following signing of the enrollment agreement. This information is then transferred to the Division of Medical Services' management information system;

- The management information system will generate a letter to the participant and the PACE organization advising that the client is now enrolled with the PACE organization with the effective date of enrollment for all services to be provided by the PACE organization;

- Enrollment continues as long as desired by the participant regardless of change in health status, until death, voluntary disenrollment, or involuntary disenrollment as described below.

- The Missouri Division of Aging (DA) will do annual level of care assessments on Medicaid eligible participants as well as private pay participants face-to-face. Should a PACE participant drop below the required level of care (LOC) of 24 points for PACE participation, but remain at or above Missouri's criteria for nursing home level of care (LOC) of 18 points, eligibility for PACE participation would continue. A participant's health is anticipated to improve by being a PACE participant.

- The PACE provider's participant multidisciplinary team evaluates the participant's ability to live safely in the community. The Missouri Division of Aging (DA) involves the participant in their service planning and care planning in collaboration with the PACE provider and the Division of Medical Services (DMS), to determine the participant's capacity to consent. If the DA and the PACE provider disagree about the safety of the participant living in a community setting, discussions would be held with the Missouri Division of Medical Services to review documentation and come to a decision.

- The state administering agency, the Missouri Department of Social Services (DSS), Division of Medical Services (DMS), receives a monthly enrollment status report, as well as financial and quality of services reports. These reports are analyzed monthly to determine that appropriate payments and adjustments are made to the PACE provider.

B. Enrollee Information (Please describe the information to be provided to enrollees):

Once the participant signs the enrollment agreement, the PACE provider gives the enrollee: a copy of the enrollment agreement; a PACE membership card; an emergency sticker to be posted in the enrollee's home in case of an emergency; a sticker for the enrollee's Medicare and Medicaid card which indicates that the enrollee is a PACE participant; the member handbook, which includes an explanation of the internal PACE organization's grievance and appeals process; the additional appeal rights that may be initiated under either Medicare or Medicaid, depending upon the participants payer source. An appeal that has not been resolved to the satisfaction of the participant may be taken to a higher level internally within the PACE organization or the participant may pursue an appeals directly with the Missouri Division of Medical Services, Recipient Services Unit.

X

[redacted]

July 31, 2001
SUPPLEMENT 3 to ATTACHMENT 3.1-A
Page 10a

C. Disenrollment Process (Please describe - voluntary and involuntary):

Voluntary Disenrollment

A participant may voluntarily disenroll at any time by providing the PACE organization with advance written notice. The participant's benefits will terminate on the first day of the month following participant's written request to disenroll or the most expedient disenrollment date that can be agreed upon to ensure a coordination of disenrollment date and return to Medicare/Medicaid fee-for service. The participant will receive a letter from the Missouri Department of Social Service (DSS), Division of Medical Services (DMS), advising of the voluntary disenrollment with an effective date of disenrollment and the return to fee-for-service. The participant may re-enroll in the PACE organization provided that they continue to meet the admissions and eligibility criteria.

Involuntary Disenrollment

A participant may be involuntarily disenrolled for any of the following reasons: participant fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE provider after a 30-day grace period; participant engages in disruptive or threatening behavior, such as behavior jeopardizing his or her health or safety, or the safety of others, or a participant with decision making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement; participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE provider agrees to a longer absence due to extenuating circumstances; participant is determined to no longer meet the State Medicaid nursing home level of care requirements and is not deemed eligible; PACE program agreement with HCFA and the State administering agency is not renewed or is terminated; or PACE provider is unable to offer health care services due to the loss of State licenses or contracts with outside providers. If a PACE provider proposes to disenroll a participant who is disruptive or threatening, the provider must document the following information in the participant's medical record: reason for proposing to disenroll the participant and all efforts to remedy the situation. A PACE provider may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety or the safety of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments. Before an involuntary disenrollment is effective the Division of Aging (DA) and the Division of Medical Services (DMS) must review and determine in a timely manner that the PACE provider has adequately documented acceptable grounds for disenrollment.

In disenrolling a participant, the PACE provider must take the following actions: use the most expedient process allowed under Medicare and Medicaid procedures, as set forth in the PACE program agreement; coordinate the disenrollment date between Medicare and Medicaid (for a participant who is eligible for both Medicare and Medicaid); and give reasonable advance notice to the participant. Until the date enrollment is terminated, the following requirements must be met: PACE participants must continue to use PACE provider services and remain liable for any premiums; and PACE provider must continue to furnish all needed services.

To facilitate a participant's reinstatement in other Medicare and Medicaid programs after disenrollment, the PACE provider must: make appropriate referrals and ensure medical records are made available to new providers in a timely manner; PACE provider work with the Division of Aging (DA), Division of Medical Services (DMS) and HCFA to reinstate the participant in other Medicare and Medicaid programs for which the participant is eligible.

D. The State assures that before an involuntary disenrollment is effective, it will review and determine in a timely manner that the PACE organization has adequately documented grounds for disenrollment.

E. In the event a PACE participant disenrolls or is disenrolled from a PACE program, the State will work with the PACE organization to assure the participant has access to care during the transitional period.

F. The State assures it will facilitate reinstatement in other Medicaid/Medicare programs after a participant disenrolls.

G. The State assures that the State PACE requirements and State procedures will specify the process for how the PACE organization must submit participant information to the State.

V. Marketing: For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that a process is in place to review PACE marketing materials in compliance with Section 460.82(b)(ii).

VI. Services: The following items are the medical and remedial services provided to the categorically needy. (Please specify):

State agrees to provide Medicaid State Plan approved services as shown in the Medicaid State Plan 3.1-A.

The PACE benefit package for all participants, regardless of the source of payment, includes the approved Missouri Medicaid State Plan services, and multidisciplinary assessment and treatment planning and other services determined necessary by the multidisciplinary team to improve and maintain the participant's overall health status.

The State assures that the State agency that administers the PACE program will regularly consult with the State Agency on Aging in overseeing the operation of the PACE program in order to avoid services duplication in the PACE service area and to assure the delivery and quality of services to the PACE participants.

VII. Decisions that require joint HCFA/State Authority

A. For State Medicaid Agencies also acting as PACE State Administering Agencies, waivers will not be granted without joint HCFA/State agreement:

1. The State will consult with HCFA to determine the feasibility of granting any waivers related to conflicts of interest of PACE organization governing board members.

2. The State will consult with HCFA to determine the feasibility of granting any waivers related to the requirements that: members of the multi disciplinary team are employees of the PACE organization; and that members of the multi-disciplinary team must serve primarily PACE participants.

B. Service Area Designations: The State will consult with HCFA on changes proposed by the PACE organization related to service area designation.

C. Organizational Structure: The State will consult with HCFA on changes proposed by the PACE organization related to organizational structure.

D. Sanctions and Terminations: The State will consult with HCFA on termination and sanctions of the PACE organization.

VIII. State Licensure Requirements

For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that Life Safety Code requirements are met for facilities in which the PACE organization furnishes services to PACE participants in accordance with Section 460.72(b), unless HCFA determines that a fire and safety code imposed by State law adequately protects participants and staff.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

The State agency will establish rates for reimbursement as defined and determined by the Division of Medical Services in accordance with 42 CFR 460.182.

PACE is a fully capitated comprehensive service delivery system that includes: primary care, restorative therapy, transportation, home health care, inpatient acute care, and nursing facility long-term care when home and community-based services are no longer appropriate. Enrollment is always voluntary and participants have the option to disenroll at any time. The PACE provider receives a monthly capitation for each enrollee from both Medicare and Medicaid. The program is cost-neutral. Participants are appropriate for nursing home care and the capitated rate paid to the PACE provider should be no more than the Medicaid cost for services provided for individuals residing in nursing homes in the service area.